INDIANA PASARR PROGRAM
DEMENTIA ASSESSMENT CHECKLIST

State Form 47182 (R / 2-99) / BAIS 0029

This form shall become a **CONFIDENTIAL RECORD** upon completion in accordance with 42 CFR 483.100 et. al.

* This State agency is requesting disclosure of your Social Security number, under 42 CFR 483.100 et. al. Disclosure is voluntary, and you will not be penalized for refusal.

Name of applicant / resident	Social Security number *	Date of birth

Name of nursing facility	Telephone number

Address (*number and street, city, state, ZIP code*)

DEMENTIA ASSESSMENT CHECKLIST

Federal PASARR regulations require documentation of a diagnosis of dementia (*including Alzheimers Disease and related disorders*) if an individual is excluded from PASARR / MI Level II assessment based on the dementia exclusion. An individual with a primary / principal diagnosis of a major mental illness (MI) or who is developmentally disabled (MR/DD) may not be excluded from Level II. To document the dementia diagnosis, the sections of this form may be completed or other documents which address the criteria in Sections 1-5 may be obtained. This documentation must be retained on the individual's active record in the NF. The purpose is to minimize the risk of overlooking potentially reversible conditions that may be causing or mimicking dementia.

If this form is used, ALL sections must be completed. At a minimum, the physician must sign and date the form. If sections are completed by different persons, the person completing it must also sign and date that part. Information must be current in that the patient's condition has not changed since testing results were obtained. Information may be obtained from the phyisican's current records, hospital summaries, etc.

NOTE: The nursing facility is responsible to maintain on file acceptable documentation of dementia for any person for whom the exclusion is claimed.

1. **DSM Criteria:** For dementia, all areas must be checked "Yes".

☐ Yes ☐ No A. Evidence of short-term and long-term memory loss. (*see part 2 below*)

B. One or more of the following:

☐ Yes ☐ No 1. Impaired abstract thinking;

☐ Yes ☐ No 2. Impaired judgement;

☐ Yes ☐ No 3. Other higher cortical dysfunction (*e.g. aphasia, apraxia, agnosia, constructional dyspraxia*).

☐ Yes ☐ No C. A & B significantly interferes with work or usual activity.

☐ Yes ☐ No D. Not occurring exclusively during the course of delirium.

☐ Yes ☐ No E. Insidious onset with generally progressive deterioriating course.

☐ Yes ☐ No F. Exclusion of other specfic causes of dementia by history, physical and laboratory tests. (*See parts 3-4 below*).

2. **Mental Status Examination:** At least one must be checked. Enter results and interpretation. Attach an additional page if needed.

☐ Short Portable Mental Status Questionnaire (SPMSQ) Score: _____/_____ errors

☐ Folstein Mini Mental Status Exam Score: _____/_____ errors

☐ Halstead-Reitan, Luria Nebraska or other neuropsychological assessment battery _____

☐ CAMCOG-Cambridge Cognitive Examination portion of CAMDEX Score: _____ errors

☐ Kahn-Goldfarb MSQ; Face-Hand Test Score: MSQ _____ errors

FHT _____ errors

☐ CBRS-Cognitive Behavior Rating Scale Score: _____

☐ Mattis Dementia Rating Scale Score: _____

☐ Blessed Dementia Scale Score: _____

☐ Wechsler Tests (WAIS-R or WMS-R) Scores: _____

_____ _____

☐ Other: _____ Score: _____

Interpretation(s):

Testing by: (*If Mental Status Exam done by someone other than the physician*)	Date (*month, day, year*)

Affiliation:	Credentials

(*Continued on the reverse side*)

DEMENTIA ASSESSMENT CHECKLIST (*Continued*)

3. **MEDICAL PROCEDURES:** Screening and laboratory procedures performed to either substantiate dementia or to rule out other possible causes of dementia. (*Check all that have been completed and reviewed.*)

- ☐ Medication Review to rule out medication effects
- ☐ Vision / hearing problems
- ☐ Environmental change
- ☐ Assessment for depression and other psychiatric disorders
- ☐ Brain trauma / concussion
- ☐ ASHD / CHF / Alcoholism / Anemia / etc.
- ☐ Thyroid Function
- ☐ Urinalysis
- ☐ Electrolyte Panel
- ☐ Screening Metabolic Panel
- ☐ B_{12} and Folate Levels
- ☐ Chest Xray
- ☐ Electrocardiogram
- ☐ Other: _____
- ☐ CBC
- ☐ CT Scan *
- ☐ MRI *
- ☐ EEG *
- ☐ PET *
- ☐ Biopsy *

Results / interpretation:

* Not required. Record results if completed for purposes other than completion of this form.

4. **PATIENT / FAMILY HISTORY:** As complete a history as possible should be obtained to supplement the detection of occult medical illness in number 3 above: (*NOTE: May be provided by family or other responsible party.*)

5. **OTHER PROCEDURES** used to substantiate diagnosis or to rule out possible causes of dementia: (*Indicate "None" if applicable*.)
Procedure(s):

Interpretation:

6. In your best judgment, is the dementia condition expected to be reversible, e.g., dementia following surgery, due to hypothyroidism, etc.? Or is it irreversible and anticipated to worsen?

☐ REVERSIBLE ☐ IRREVERSIBLE Comments:_____

If reversible, the NF should monitor and assure necessary services are provided for the individual's recovery.

7. Does the person have behavior problems? ☐Yes ☐ No	Is the person a danger to self or others? ☐Yes ☐ No

If Yes to number 7: Explain, including recommended strategies to deal with problems.

Information completed by (*If other than the physician*):

Name	Date (*month, day, year*)
Affiliation	Credentials

This documentation must be certified by the physician:

Signature of physician	Printed name of physician	Date (*month, day, year*)